STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO A. BUILDING	(X3) DATE SURVEY COMPLETED 05/21/2012		
		155167	B. WING	A PROPERTY OF THE COLUMN	00/21/2012
NAME OF F	PROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP CODE PRESBYTERIAN DR	
WESTMI	NSTER VILLAGE I	NORTH		APOLIS, IN 46236	
(X4) ID PREFIX		STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION
TAG	`	R LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE DATE
F0000		,			
F0000	State Licensur included the Ir Complaint INO Unsubstantiate evidence. Survey dates: 18, & 21, 2012 Facility number Provider number: Survey team: Christi Davidso Diana Zgonc, Connie Landm Lora Brettnach Census bed ty SNF: 38 SNF/NF: 61 Residential: 8 Total: 186 Census by pay Medicare: 25	0107129. 0107129 - ed due to lack of May 14, 15, 16, 17, er: 000084 per: 155167 100284600 on, RN-TC RN pan, RN per, RN prec: RN	F0000		
	Medicaid: 48 Other: 113				
	Total: 186				
LABORATOR	Y DIRECTOR'S OR PRO	OVIDER/SUPPLIER REPRESENTATIVE'S S.	IGNATURE	TITLE	(X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

F28W11

000084

PRINTED: 06/05/2012 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155167			(X2) MULTIPLE CO	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 05/21/2012
	PROVIDER OR SUPPLIE	R	11050 F	ADDRESS, CITY, STATE, ZIP CODE PRESBYTERIAN DR APOLIS, IN 46236	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	findings cited i IAC 16.2.	cies reflect state n accordance with 410 completed on May 23,			

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Event ID: F28W11

Facility ID: 000084

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X2)			(X3) DATE S	(3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING COMPLETED			ETED	
		155167	B. WINC			05/21/	2012
	PROVIDER OR SUPPLIEF			11050 F	ADDRESS, CITY, STATE, ZIP CODE PRESBYTERIAN DR APOLIS, IN 46236		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	1	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	X (EACH DEFICIENCY MUST BE PERCEDED BY FULL		I	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0176 SS=D	DEEMED SAFE An individual residrugs if the interby §483.20(d)(2) practice is safe. Based on recoland observation ensure resident self-administer medications were for 1 of 10 resident medication pass. Findings include During observation pass on 5/17/1 LPN #1, Resident physician's ord micrograms (mr. (SQ) injection for Resident #193 always gives the LPN #1 hander medication and herself. During #1 at that time, PRN (as needed know she (Resident general self-medication on the coordinator on the coordinator on the self-medication and the self-medicating particles.	disciplinary team, as defined of the resident # 193) was a defined as defined of the resident # 193) was a defined to the resident # 193).	F017	76	Submission of this plan of correction shall not constitute be construed as an admission Westminster Village North that the allegations contained in the survey report are accurate or reflect accurately the provision nursing care and service to the Residents at Westminster Villa North. F 176 One must not that this Resident is alert and oriented, as evidenced by the that her BIM Score = 15. The Resident, has in fact, been self-injecting this medication when at home. It must also be noted that the nurse in questic remained at the bedside while Resident self-injected the medication. Thus, the Reside remained under the constant supervision of a licensed nurse this observation. This Residents been discharged to home This is an isolated event. At the time there are no other Reside in the Health Center that self-administer medications. Thus, no other Resident's competency regarding her ability and the self-administer medications.	by t t is n of e age e fact e nt e. ent dent . inis ents	06/04/2012

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X		(X2) M	X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DITT	LDING	00	COMPLETI	ED
		155167				05/21/20	12
			B. WIN		ADDRESS SITY STATE TIP CODE		
NAME OF I	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP CODE		
\4/E0T4		IODTII			PRESBYTERIAN DR		
WESTMINSTER VILLAGE NORTH			INDIAN	IAPOLIS, IN 46236			
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PERCEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		TE C	OMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	Resident # 193	3 was			to self-inject this medication.	The	
	self-administering medications.				attending physician was		
					contacted and an order was		
	During an inter	view with the resident			secured for the Resident to		
	_				self-administer the medication		
		10:35 A.M., she			question. The same was note on the Resident's care plan.	eu	
		nad always given			Please refer to Attachements	_{#1}	
	1	ction at home and			#2 and #3 regarding Residen		
		here in the facility for			#193. Subsequest to this citir		
	rehabilitation.				the policy and procedue regar		
					Resident Self-Administration of	of	
	The record for	Resident #193 was			Medications has been reviewe	ed	
	reviewed on 5/17/12 at 1:30 p.m., and				and revised, as has the		
	lacked docume				Self-Administration Assessme	nt	
					form itself. Please refer to		
	assessment, a	-			Attachments #4 and #5.		
	1	lers for the resident to			Inservice training has been made available to all licensed nurses		
	self-administer	medications.			and Q.M.A.'s regarding the sa		
					as evidence by Attachement #		
	A current facilit	ty policy, dated 3/11,			Going forward, the policy for	0.	
	and titled "Med	lication Administration			resident self-administration of		
	Procedures Se	elf-Administration of			medications will be addressed		
		nd provided by the			during the orientation process	for	
		sing on 5/21/12 at 2:25			all newly hired licensed nurse:		
	P.M., included:	•			and Q.M.A.'s. Also, a copy of		
	i .ivi., iriciuueu.	•			revised policy will be placed in		
					the binder housing the MAR's	-	
	1	ents who desire to			each unit; thus, it can be read accessed should the need to	-	
	self-administer	medications are			so arise in the future. As a	JU	
	permitted to do	so if the facility's			quality assurance measure, e	ach	
	interdisciplinar	y team has determined			unit coordinator will monitor th		
		e would be safe for the			Residents on his/her unit and		
	· ·	ther residents of the			advise the Quality Assurance		
		ler to self-administer			Nurse should any additional		
	1				Residents express a desire to		
		by the physician.			self-administer medications in		
		. Upon request of a			future. Additionally, in the future		
	resident to self				the agenda of the facility's Qu	ality	
	medications, th	ne interdisciplinary			Assurance Meetings will be		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	ETED
		155167	B. WIN			05/21/	2012
					ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER	L			PRESBYTERIAN DR		
WESTMI	NSTER VILLAGE N	IORTH			APOLIS, IN 46236		
(X4) ID	CLIMMA DAY C	TATEMENT OF DEFICIENCIES		ID	,	ı	(V5)
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	DATE
1710		•	+	mo	expanded to include a status		DATE
		ician will be consulted			report for any Resdients that h	ave	
	for evaluation.				been deemed appropriate to		
	I	will administer the			self-administer medications. T	he	
		cations until the			Director of Nursing will monitor	r.	
		team completes an					
		id a physician's order is					
	obtained.						
	3. The interdis	ciplinary team will					
	assess the resi	dent's ability to					
	self-administer	medications safely at					
	least quarterly	and as needed. A.					
	The resident is	instructed in the use					
	of the package	, purpose of the					
		ading of the label and					
		nedication doses. B.					
		then requested to					
		on each package and					
		t time the medication					
		n and any other special					
		use. C. The resident					
		nonstrate the removal					
		on from the package					
		e of non-solid dosage					
	forms such as	•					
		e steps involved in					
		E. The results of the					
		team assessment are					
	recorded in the	medical record."					
	3.1-11(a)						
			1				

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	TOF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA OF CORRECTION IDENTIFICATION NUMBER: 155167	(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 05/21/2012		
	ROVIDER OR SUPPLIER NSTER VILLAGE NORTH	STREET ADDRESS, CITY, STATE, ZIP CODE 11050 PRESBYTERIAN DR INDIANAPOLIS, IN 46236				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	BE COMPLETION		

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Event ID: F28W11

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STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY			SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DIII	LDING	00	COMPL	ETED
		155167	B. WIN			05/21/	2012
			B. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER	8					
\A/E 0.T. 411	NOTED \	IODTII			PRESBYTERIAN DR		
WESTMIII	NSTER VILLAGE N	IORTH		INDIAN	APOLIS, IN 46236		
(X4) ID	SUMMARY S'	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0334	483.25(n)						
SS=B	, ,	D PNEUMOCOCCAL					
	IMMUNIZATION	S					
	The facility must	develop policies and					
	procedures that						
	(i) Before offering	g the influenza immunization,					
	each resident, or	r the resident's legal					
	representative re	eceives education regarding					
	the benefits and	potential side effects of the					
	immunization;						
		t is offered an influenza					
		ctober 1 through March 31					
	•	the immunization is					
	•	indicated or the resident has					
		munized during this time					
	period;						
		or the resident's legal					
		as the opportunity to refuse					
	immunization; ar						
		's medical record includes					
		hat indicates, at a minimum,					
	the following:	sident or resident's legal					
	, ,	ras provided education					
		nefits and potential side					
		za immunization; and					
		sident either received the					
	, ,	ization or did not receive the					
		ization due to medical					
	contraindications						
	The facility must	develop policies and					
	procedures that						
		g the pneumococcal					
		ach resident, or the resident's					
		tive receives education					
	regarding the be	nefits and potential side					
	effects of the imr	•					
		t is offered a pneumococcal					
		nless the immunization is					
		indicated or the resident has					
	already been imi	munized;					
	1		1				1

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) M			(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A DUIL DING	COMPLETED	
		155167	A. BUILDING		05/21/2012
			B. WING	ET ADDRESS SITY STATE ZID CODE	
NAME OF P	ROVIDER OR SUPPLIEF	₹		ET ADDRESS, CITY, STATE, ZIP CODE	
= 0=				50 PRESBYTERIAN DR	
WESTMINSTER VILLAGE NORTH		NORTH	INDI	ANAPOLIS, IN 46236	
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PERCEDED BY FULL	PREFIX		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
	(iii) The resident	or the resident's legal			
	representative h	as the opportunity to refuse			
	immunization; aı	nd			
	(iv) The resident	's medical record includes			
	documentation t	hat indicated, at a minimum,			
	the following:				
		sident or resident's legal			
		as provided education			
		enefits and potential side			
	-	nococcal immunization; and			
	` '	sident either received the mmunization or did not			
	-	umococcal immunization due			
		aindication or refusal.			
		ative, based on an			
	assessment and				
		n, a second pneumococcal			
		ay be given after 5 years			
	following the firs	t pneumococcal			
	immunization, ui	nless medically			
		or the resident or the			
	_	representative refuses the			
	second immuniz	ation.			
	Based on reco	rd review and	F0334	Regrettably, the facility was	06/04/2012
	interview, the fa	acility failed to ensure		unaware that it was not	
	consents were	•		acceptable to secure an initia	1
		provided for residents		consent for annual vaccines,	
		offluenza vaccine for 3		ongoingly. Due to the fact that	
	_			the facility's influenza vaccina program is, obviously, a seas	l l
		reviewed for influenza		event, there are no corrective	l l
	,	dent # 13, # 109 and #		actions that can take place fo	l l
	1).			Residents cited in this survey	
				None of the residents	
	Findings includ	le:		experienced any negative	
	9			outcomes due to this paper	
	The record lack	ked documentation of		compliance error. Howeve	
				preparation for the upcoming	l l
	-	or education for the		season, the facility has compl	
		nes for the 2011		the following: the facility's poli	-
	season for the	following residents:		and procedure has been mod to denote the need for a new	itied

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A BIII	LDING	00	COMPLETED
		155167	B. WIN			05/21/2012
			B. WII		ADDRESS, CITY, STATE, ZIP CODE	
NAME OF F	PROVIDER OR SUPPLIE	R			PRESBYTERIAN DR	
WESTMI	NSTER VILLAGE N	NORTH			APOLIS, IN 46236	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE
TAG	REGULATORY OF	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
	1. The record	for Resident # 13 was			informed consent/declination f	orm
	reviewed on 5/	17/12 at 10:15 A.M.			each year, as evidenced by	
	The record inc	luded consent for the			Attachement #1. The	ala a
	influenza vacci	ne originally signed on			consent/declination form has a been revised in an effort to off	
		nfluenza vaccine was			helpful information in an easy	
	given 10/6/11.	machiza vaccine wac			understand format, as evidence	
	914011 10/0/11.				by Attachment #2. The Unit	
	2 The record t	or Resident # 109 was			Coordinator will be responsible	
					for the presentation of the new	1
		17/12 at 10:15 A.M.			form to the Residents and/or	
		luded consent for the			Responsible Party each year.	
		ne originally signed on			The Infection Control Nurse w monitor. Additionally, as the	
	9/8/10 and influenza vaccine given				time to initiate this season's	
	10/6/11.				influenza immunization progra	m l
					draws near, the Infection Cont	
	3. The record f	or Resident # 1 was			Nurse will seek the approval o	
	reviewed on 5/	17/12 at 10:15 A.M.			the Resident Council Presider	
		luded consent for the			address the Council regarding	
		ne originally signed on			role of the influenza vaccine in	
		fluenza vaccine given			prevention. Additionally, in th	
		ilueriza vaccine giveri			future, the agenda of the facility Quality Assurance Meetings w	
	10/4/11.				be expanded to include a statu	
					report of the influenza vaccina	
		view with the Assistant			program at the appropriate	
	Director of Nur	sing on 5/16/12 at 2:15			seasonal time.	
	P.M., she indic	ated she was not sure				
	if the medical r	ecord had				
	documentation	for the residents'				
	consent or edu					
		nfluenza vaccines last				
	year (2011).					
ı	y car (2011).					
ı	During an inter	view on 5/16/12 at				
	3:25 P.M. with	the Assistant Director				
		e indicated no further				
	_	for consents or				
	education of th					
	i cuucation of th	E 1691061119 101				

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		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO		(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 155167	A. BUILDING	00	COMPLETED 05/21/2012
		100107	B. WING		00/21/2012
NAME OF F	ROVIDER OR SUPPLIEI	R		ADDRESS, CITY, STATE, ZIP CODE PRESBYTERIAN DR	
 WESTMI	NSTER VILLAGE N	NORTH		IAPOLIS, IN 46236	
				T	
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION
TAG		NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE DATE
ind		ines could be found.	IAG	·	DATE
	i iiiiueiiza vacci	ines codia de lodria.			
	3.1-13(a)				
	3.1-13(a)				
			1		
			1		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVI					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	A. BUILDING			ETED
		155167	B. WING			05/21/	2012
NAME OF D	ROVIDER OR SUPPLIER		.	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	NO VIDER OR SUFFLIER				PRESBYTERIAN DR		
WESTMI	NSTER VILLAGE N	IORTH		INDIAN.	APOLIS, IN 46236		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	<u> </u>	TAG	DEFICIENCY)		DATE
R0240	410 IAC 16.2-5-4 Health Services						
		e, and assistance with					
	· '	living, shall be provided					
	based upon indiv						
	preferences.						
	Based on obse	rvation, record review,	R0240	0	Please note that this was an		06/04/2012
		he facility failed to			isolated incident. One must no		
		tions were not left in a			that upon discovering that this		
		to be taken later			incident occurred, the Unit Manager immediately went to	the	
	without supervi				resident's apartment to ensure		
	residents obser				that the resident was able to ta		
		ninistration times			the medications without incide	nt.	
	(Resident #101				The Quality Assurance Nurse		
	(Nesident #101	, QIVIA π2).			Manager immediately disciplin		
	Findings includ	0.			and reinserviced the Q.M.A wl left the medication in the	no	
	i indings includ	С.			resident's apartment, as		
	The recent for l	Decident #101es			evidenced by Attachment #1.		
		Resident #101 was			One must note that the facility		
	reviewed on 5/2	21/12 at 1:05 P.M.			had provided inservice educat		
	Current diagno	ses included but were			to this employee as well as the entire nursing department	9	
	_	ses included, but were hyperparathyroidism,			regarding appropriate medicat	ion	
	-	· · · · · · · · · · · · · · · · · · ·			administration on 4/30/12, as		
	-	CHF (congestive heart			evidenced by Attachment #2.		
	•	s leg syndrome, and			The Administrative Nurse		
	,	obstructive pulmonary			re-assessed all residents		
	disease) exace	rbation.			currently self-administering medications to ensure proper		
					protocol is being followed.		
	During the med				Inservice education regarding		
		5/21/12 at 9:00 A.M.,			Medication Administration has		
		bserved preparing			again been provided to staff as	s	
		s medications. After			evidenced by Attachment #3.		
	the medications	s were prepared, QMA			Subsequent to this citing, the policy and procedure regarding	_	
	#2 went to the	resident's door and			Resident Self-Administration of	-	
	knocked. QMA	#2 then indicated the			Medications has been reviewe		
	resident was us	sually in the shower at			and revised as evidenced by		
		A #2 unlocked and			Attachment #4. Inservice train	ning	

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IDENTIFICATION NUMBER: 151617 151	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY		
NAME OF PROVIDER OR SUPPLIER WESTMINSTER VILLAGE NORTH WESTMINSTER VILLAGE NORTH INDIANAPOLIS, IN 46236 SUMMANY STATIMENT OF DEPOLICIONS (EACH DEPOLICINCY MUST BE PERCEDED BY PELL REGISLATORY OR LISC DIMINITYING INDIRATION) entered the resident's apartment, calling to the resident and had her medications. The resident replied to leave them by the sink. QMA #2 went to the bathroom door and knocked, informing the resident shad her medications. The resident replied to leave them by the sink. QMA #2 went to the sink in the living area. QMA #2 indicated the resident usually placed a napkin by the sink where she wanted her medications left. QMA #2 placed the medications beft. QMA #2 placed the medications beft. QMA #2 placed Amlodipine, Aspirin, Doxazosin, Famotidine, Furosemide, Omeprazole, Polyethyline Glycol, Sertraline, Tab-A-Vite, Clonidine HCL, and DOK (Docusate Sodium), QMA #2 had indicated, while preparing Resident #101's medication, inhalers were in the resident's noom and she took care of the inhalers herself. The current recapitulation of physician's orders, dated April 1, 2012, lacked orders for inhalers or other medications to be left at the bedside, or the resident's Service Plan indicated for management of oral	AND PLAN	OF CORRECTION		A. BUI	A. BUILDING 00			
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State Form Event ID: F28W11 Facility ID: 000084 If continuation sheet Page 12 of 14

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	OVIDER/SUPPLIER/CLIA (X2) MULT		NSTRUCTION	(X3) DATE	(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	CATION NUMBER: A. BU		00	COMPLETED		
		155167 B. WIN				05/21/2012		
			B. WIIV		ADDRESS, CITY, STATE, ZIP CODE			
NAME OF I	PROVIDER OR SUPPLIEF	8			PRESBYTERIAN DR			
WESTMI	NSTER VILLAGE N	NORTH			APOLIS, IN 46236			
				<u> </u>	711 0210, 114 10200		aus)	
(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIES			ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)	
TAG	(EACH DEFICIENCY MUST BE PERCEDED BY FULL			TAG	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION DATE	
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)			IAU		DATE		
	prepare and take all prescribed oral medication reliably and safely, including administration of correct dosage at appropriate							
	times/intervals") the resident's score							
	was 15 - "Unal	ole to take medication						
	unless administered by someone							
	else".							
	A Social Services Progress Note, dated 5/15/12, indicated "STM (short term memory) deficit."							
	A Momorandum dated 4/20/12							
	A Memorandum, dated 4/30/12,							
	provided by the Assisted Living Manager on 5/21/12 at 1:00 P.M., titled "Reminders for QMAs"							
	indicated:							
	" No meds sh	nould be left at						
	residents' bedsides unless ordered to be at bedside, and the resident has been assessed as safe to self-administer meds"							
	A facility policy, dated 1/17/07, titled							
	"Administration of Medications",							
	•							
	provided by the Assisted Living Manager on 5/21/12 at 1:00 P.M.,							
	_	2 1/ 12 at 1.00 P.W.,						
	indicated:							
	I -	safely administer						
	medications as	s prescribed						
	Procedure:							
	8. Administe	er oral medication and						
	remain with resident while he/she							
takes the medication"								
	1		1					

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155167	(X2) MULTIPLE CO A. BUILDING B. WING	00					
	ROVIDER OR SUPPLIE NSTER VILLAGE I		STREET ADDRESS, CITY, STATE, ZIP CODE 11050 PRESBYTERIAN DR INDIANAPOLIS, IN 46236						
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)	TION LD BE ROPRIATE	(X5) COMPLETION DATE			

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